VERMONT
DEPARTMENT OF VERMONT HEALTH ACCESS

VCCI History and Summary

The Vermont Chronic Care Initiative (VCCI) is a statewide program that provides care coordination and intensive case management services to non-dually-eligible Medicaid beneficiaries with one or more chronic conditions, with a focus on improving outcomes and reducing unnecessary utilization for the top 5% high-utilizing Medicaid beneficiaries in the state. The VCCI modified its approach to focus on the top 5% in June 2011. The program is funded and operated by the state's Department of Vermont Health Access. Because most providers are reimbursed by the state's Medicaid program through a fee-for-service model, reductions in unnecessary spending achieved by the program translate directly to savings to the state's Medicaid program budget.

The program reaches beneficiaries primarily through a corps of case managers and care coordinators – usually nurses or social workers – that operate either as field-based agents serving a region or as permanently embedded resources within provider organizations with a high-volume of program clients. Locations include private practices, FQHC's and several high volume hospitals. Multiple hospitals also provide secure data transfers daily that provides the program with near-real-time data on client utilization. The program works with a contractor that performs the data processing and analytics – including daily reports to field and embedded program staff on real-time client utilization, that are used to guide response activities.

Beneficiaries qualify for the program if they are in the top 5% or demonstrate high utilization patterns including hospital ED and inpatient admissions. Generally they will have one or more chronic conditions such as asthma, congestive heart failure, depression, diabetes coronary artery disease, COPD, low back pain, mental health and substance use/abuse disorders, as well as polypharmacy . The program further targets beneficiaries determined to be "impactable" based on an analysis of clinical acuity and recent utilization patterns; this analysis is conducted by the program analytics contractor, and considers each candidate client's Chronic Disability and Payment System (CDPS) score, their actual per-member-per-month cost to the Medicaid program, the number of chronic conditions, the number of emergency room and inpatient encounters, and evidence of fragmented, uncoordinated care – for example, several encounters with different providers in a short amount of time. Candidate clients are also identified through direct referrals from primary care providers and ED staff, from field and embedded program staff, as well as other internal and external statewide partners.

When possible, providers provide a "warm hand-off" of prospective clients to program staff while the client is in the provider setting. In the absence of this, program field staff use a number of other methods to engage new clients, though this process can often be more time-consuming and challenging, in terms of both of making contact with candidate clients and establishing a trusting relationship.

Clients successfully on-boarded into the program receive a "social needs assessment" and a "behavioral risk assessment." Depending on the client's specific needs, a number of other disease-specific assessments – for example, for lower-back pain, diabetes, chronic obstructive pulmonary disease, etc. – are performed, as well as a "transitions in case assessment" for clients exiting inpatient care.

The program provides several types of special supports to clients on an ongoing basis, including: coaching clients on motivation, health literacy, and self-management skills; facilitating client engagement with their primary care providers

and mental health agencies; developing a care plan and action plan in collaboration with the client and their providers; assessing social and other non-clinical barriers to health and coordinating client access to available state or local resources – e.g., for housing, food and fuel, transportation, drug rehabilitation services, and financial support for medications or other treatment needs; reviewing medication lists to ensure that evidence-based prescribing guidelines have been followed; and providing more intensive transitional supports following inpatient admissions or emergency department visits. Selecting the appropriate mix of supports for each client is informed by the real-time analytics provided by the program contractor, which help to identify gaps in care and other opportunities to intervene with the client. Interactions with higher-risk clients are typically performed face-to-face; interactions with lower-risk clients are more likely to be telephonic.

The VCCI is funded through the state Medicaid office. Additional grant funding to local Health Service Areas support Medicaid beneficiaries who do not fall into the top 5%'; services are provided by the state's Blueprint for Health program (a statewide, multi-payer initiative to improve primary care through the creation of Patient-Centered Medical Homes and Community Health Teams).

In 2011, the VCCI demonstrated significant improvements in adherence to evidence based care for all members with one of 11 chronic conditions followed by VCCI staff versus the population without VCCI interventions with the same conditions. The program also documented a reduction in ED visits of 10% over baseline; as well as a 14% decline in inpatient admissions.

In state fiscal year 2012, the VCCI transitioned to a focus on the top 5% of the Medicaid population with the highest utilization; and entered into a 100% risk based vendor contract. The 2012 evaluation data demonstrates some variability in adherence to evidence based care for the same 11 chronic conditions measured in FY 2011with clear improvement on 6 of 12 measures for the intervened population of the highest acuity versus those without intervention by VCCI staff. For FY 2012 utilization measures, the top 5% cohort was compared to the top 5% in 2011 as the new baseline. The VCCI demonstrated an 8% reduction in ED utilization among the top 5% cohort in 2012 as compared to FY 2011; a 4% decline in ED utilization and 11% decline in readmission rates in FY 2012 as compared to FY 2011. The VCCI achieved financial savings in FY 2012 of roughly $11.5 million over anticipated costs for FY 2012.

ROI Population of 8,824 Members			
	IP	ReAdmit	ER
FY11 Rate	517.7509	87.01695	1521.346
FY12 Rate	476.0152	77.41207	1460.918
% Change FY11 to FY12	-8.06%	-11.04%	-3.97%